Meeting Maine's Need for Frontline Workers in Long-term Care and Service Options

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Background

Across Maine and the nation, thousands of workers, predominantly women, provide assistance and health care for elders, and adults and children with disabilities. These paraprofessionals include certified nursing assistants (CNAs), personal support specialists (PSSs), home health aides (HHAs), and direct support professionals (DSPs). They work in hospitals, nursing homes, residential and assisted living facilities, and people's homes. Together they provide eight out of every ten hours of paid care received by long-term care consumers.[i]

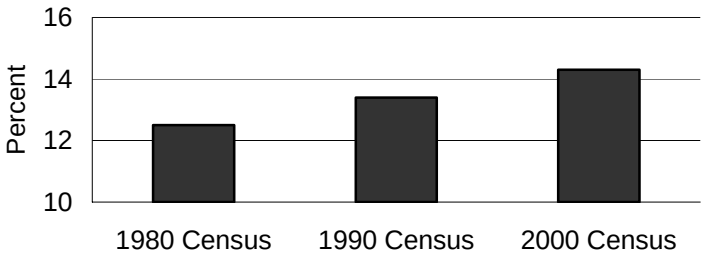
The Maine Department of Labor estimates that there were about 17,600 direct care workers employed in 2005.[ii] This does not include self-employed workers in private pay arrangements that are difficult to track. As baby boomers retire over the next 20 years, the demand for direct care and personal assistance services will continue to grow making direct care occupations some of the highest demand jobs in the state.

Problem Statement and Trends

The increasing demand for these frontline workers has already met with a labor shortage that will become even more critical in years to come. All of the parties in the long-term care system -- consumers, providers, and workers – have a stake in this issue. Long-term care consumers are often unable to get all the care they need. Some are on waiting lists for weeks and months. Many must try to adapt to constantly changing workers performing very intimate tasks like bathing and dressing, which diminishes the quality of their care experience. Providers scramble to find workers and entice them to stay. Workers who do stay experience the extra burden of working within a staffing shortage, adding to their stress and burnout. This situation is a public problem for Maine that needs public policy solutions.

There are several key factors contributing to the worker shortage. First is demographic: the elderly population in Maine –will continue to grow faster than the pool of traditional direct care workers. Second, long-term care providers must compete for entry-level workers with firms in other sectors that offer better compensation and/or less demanding jobs. Third, government payment policies – largely within the Medicaid program – limit the ability of long-term care providers to substantially increase the workers' compensation in order to make the jobs more attractive and competitive.[iii] Finally, workers often receive inadequate training and supervision, and often do not feel their work is valued and respected. Each of these issues will be discussed in turn.

Figure 1: Maine Residents Age 65+ as Percent of Total Maine Population

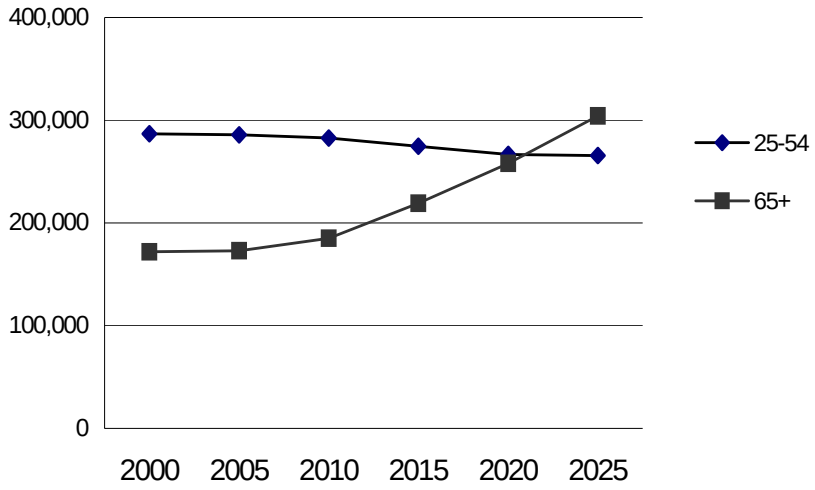


Source: Maine DHS Office of Elder Services

A Growing "Care Gap"

The proportion of Maine's elderly relative to the whole population is increasing by the decade (Figure 1) and is projected to increase from 13.9% in 1995 to 21.4% in 2025.[iv] The population most likely to require long-term care – those over 85 - will grow 26% from 2000 to 2015.[v]

Figure 2: Women of Caregiving Age and Elderly in Maine - 2000-2025 (Females aged 25-54 and elderly 65 & older)



Source: U.S. Census Bureau Population Projections

The long-term care industry has structured itself for many years on a presumed endless supply of traditional long-term caregivers – women aged 25-54. As more women entered the workforce over the past three decades, nearly tripling from 1968 through 1998, this was a reasonable assumption.[vi] More recently, welfare-to-work policies have brought a significant number of new workers into the labor force in Maine and many of them have pursued direct care positions.

But demographically, the number of women in this age cohort will fall behind the number needing the services over the long-term (Figure 2). This "care gap" will result in a growing shortage that providers have already been experiencing for several years.

The competition for entry-level workers makes the situation even more difficult. From 2002-2012, direct care worker jobs are projected to be among the top 11 fastest growing jobs in the state (Table 1). Personal and home care aide positions, for example, are expected to increase by 55% from 2002-2012. Other high demand, entry-level jobs will be cashiers, food servers, waitpersons, and retail salespersons. Many of these jobs are less demanding and some offer better compensation.

Table 1: Occupations with the Largest Projected Net Job Growth in Maine Between 2002 and 2012

	Occupation	Average Employment		Net Growth
		2002	2012	
1	Registered Nurses	13,000	16,469	3,469
2	Personal and Home Care Aides	4,853	7,502	2,649
3	Cashiers	17,616	20,017	2,401
4	Combined Food Prep. & Serving Workers, Including Fast Food	10,726	13,000	2,274
5	Social and Human Service Assistants	3,249	5,295	2,046
6	Home Health Aides	4,991	7,018	2,027
7	General and Operations Managers	11,288	12,918	1,630
8	Waiters and Waitresses	10,121	11,707	1,586
9	First-Line Supervisors/Managers of Retail Sales Workers	9,519	10,950	1,431
10	Retail Salespersons	19,240	20,669	1,429
11	Nursing Aides, Orderlies, and Attendants	9,061	10,482	1,421

Maine Department of Labor, Labor Market Information Services

Another indication of the lack of competitiveness of these jobs is the decline in interest in CNA training. The number of CNAs trained declined by 44% from 2002-2004.[vii]
Turnover rates are high and costly in long-term care agencies. The Maine Health Care Association reported an annual turnover rate in 2003 of 51% in elder care positions. Home care agencies report similar rates.

Uncompetitive Wages and Benefits

Compensation for these direct care jobs does not make them competitive with other service industry jobs, particularly given the difficult nature of the work and the added pressures brought on by understaffing. Median wages in direct care occupations are relatively low given the demands of the occupation and have not kept pace with inflation. The average median hourly wage for direct care workers in 2005 ($9.66) was about 125% of the federal poverty level wage for a family of three ($7.74). By contrast, an estimated "livable" wage, which more accurately incorporates child care, transportation, housing, and health care expenses, for a family with one parent and two children, was estimated at $18.15/hour in 2004.[viii] Personal and home care aides actually saw a 6% decline in the real value of their wages in this period. Meanwhile, food prep and retail sales workers saw median wage increases of over 6%, which is more reflective of Maine's overall economic growth for the period (Table 2).

Table 2: Direct Care Worker Median Wages from 2001 to 2005

	2001 Median	2005 Median	% Change from 2001-2005 (inflation adjusted)
Nurses Aides, Orderlies, Attendants	$9.35	$10.80	4.7%
Home Health Aides	$8.43	$9.61	3.3%
Personal and Home Care Aides	$8.28	$8.58	-6.1%
Food Preparation	$6.93	$8.75	14.4%
Retail Sales	$8.41	$9.84	6.4%

Source: Author analysis using U.S. Bureau of Labor Statistics data and the CPI calculator at http://minneapolisfed.org/research/data/us/calc/

Because of their low wages, many of these workers are eligible for and receive public assistance such as TANF and food stamps. Nationally, more than 13% of all nursing home aides and nearly 15% of all home health aides receive food stamps, compared to 5.5% of all workers in the U.S. Nearly 10% of all nursing home aides and more than 11% of all home health care aides rely on Medicaid to provide health insurance as compared to 3.9% of all workers in the U.S.[ix]

As for employee benefits, national worker surveys have indicated that as many as one out of four nursing home workers and two our of five home care workers lack health insurance coverage.[x] While nursing home and residential care facilities tend to offer health insurance to frontline direct care workers, some of these workers cannot participate because their premiums and co-payments would be too steep given their income. Home care agencies generally do not offer health insurance at all, largely because of low public funding reimbursement rates, but also because home care is generally set up as a system of per diem workers who do not have guaranteed hours, and therefore, often do not have paid time off or other benefits.

Medicaid Funding Has Not Kept Pace with Costs

In Maine, Medicaid pays for 72% of the long-term care services in nursing homes and 67% of care in assisted living and residential care facilities. Despite the importance of Medicaid for the many low-income elders and adults with disabilities in Maine, funding has not kept pace with the cost of providing long-term care in general, and the cost of retaining a quality frontline workforce in particular.

In the private market, when the demand for workers exceeds the supply of workers, businesses can increase wages and benefits to attract more people into their business. They may opt to cover the increased payroll with price increases or by taking a cut in profit. However, long-term care is, for the most part, not a free market industry. Providers cannot simply increase the "price" of long-term health care to cover increased wages and benefits when it is primarily paid with public funding controlled by state policymakers.

Since 2000, long-term care providers have experienced either outright reductions in Medicaid reimbursements or modest 1-3% cost of living increases, which amount to reductions because they do not keep pace with the actual inflationary costs of providing care. Nursing homes report that their cost increases in many areas such as food, power, and heat have far outpaced recent reimbursement rate adjustments, making it even more difficult to offer competitive wages and benefits. The shortfall in their costs against reimbursements nearly tripled from 2004-2005 (from $10 million to $27 million). Home-based care agencies are locally owned small businesses with little to no profit margin. The $14.98 they receive in total from Medicaid for a home visit (a $2.5 million cut from 2003-2004) must cover wages and all other mandatory costs of doing business (such as workers compensation, background checks, mileage costs, etc.). Thus, they have had to cut workers' hours, freeze salaries, and cut consumers' services, especially in geographically isolated areas with high travel costs. Provider agencies report they have lost workers due to these cuts in hours.

Problems with direct care staff recruitment and retention are also costly. One study estimated that turnover costs providers $2,500 per direct care worker.[xi] In addition to advertising and

retraining costs, providers often must resort to hiring contract labor – typically $20-$25 per hour.[xii] Another recourse is requiring current staff to work overtime, which adds to burnout and further turnover. Indirect costs of turnover include an initial reduction in the efficiency of new staff and a decrease in worker morale and group productivity.

Inadequate Training and Supervision Make Workers' Jobs More Difficult

Despite the important and difficult nature of their work, relatively little formal training is required for direct care staff. The federal Medicare minimum requirement (and, thus, the norm) for CNAs is 75 hours. There is no federal requirement for personal assistants. Maine requires a higher level of training for its direct care staff -- 50 hours for personal support specialists and 150 hours for CNAs.

But direct care workers have noted that they often feel under trained for the difficult situations with which they are presented. A national study noted that nurse aides need more training in areas such as behavior and cognitive disorders, as well as in interpersonal skills, including communication, teamwork, coping with death and dying, time management and new technologies.[xiii] The study also concluded that earlier clinical exposure would help weed out those who are not interested in doing direct care work, and that federal and state funds are being wasted by the large number of students who are trained each year and drop out when faced with the realities of the job.

Focus group discussions among workers in other states have indicated that supportive supervision at nursing homes is rare and supervision in home care can be nonexistent. They cite examples of nursing staff setting themselves apart and refusing to do "CNA work". They note that recognition for their work is also rare.[xiv]

Direct care work is often physically demanding, and injuries are common. Such injuries range from back strain due to lifting patients without the proper assistance equipment to assaults from combative patients. The 2000 occupational injury rate for these workers in Maine (at 6.9 incidences per 100 workers) is over twice as high as the rate for all occupations (at 3.0 incidences per hundred workers).[xv] Inadequate training may contribute to higher injury rates.[xvi]

Workers often see this work as "dead end", offering little incentive to stay in the field. There is little in the way of advancement opportunities in direct care work and often very little pay differential for years on the job.

Options for Action

To address this growing shortage of workers, policy makers, industry leaders, workers, consumers and the public must come together to craft public policies and industry practices that will both attract and retain direct care workers. With new strategies, Maine can turn this crisis around. Failure to respond to all of the elements of this worker shortage will simply drive more workers away from the direct care workforce, compromising the quality of care available.

Objectives

Responding to the direct care worker shortage involves these objectives:

- Consumers receive consistent assistance from competent caregivers that have adequate time to focus on their needs.
- Provider agencies receive increased public funding to support adequate compensation for their direct care staff so that turnover is significantly reduced and management and financial resources can be fully invested in worker training, support and retention.
- Provider agencies have quality management structures that integrate direct care workers as respected members of the care team and reward longevity and skill advancement.
- Workers earn a livable wage, have health insurance for themselves and their families, and receive work supports like child care and transportation assistance.
- Workers receive up-to-date, realistic, and ongoing training that prepares them for all the aspects of their jobs.

Current Initiatives

Several initiatives are underway to address these objectives, as described below.

The Maine Personal Assistance Services Association (PASA) was formed in 2002 and currently has over 700 members statewide, representing direct care and direct support workers and their supporters. Maine PASA, formed as a professional association, is providing recognition, information, leadership development, advocacy training and public awareness activities.

In 2003, the Maine State Employee Association (MSEA) began organizing consumer directed personal assistants in the Alpha One program. In the 2006 legislative session they collectively achieved a legislated wage increase for these 1,000 workers – the first in eight years – from $7.71 per hour to $10.00.

The Maine Direct Care Worker Coalition (DCWC) was formed in 2002 and is now a network of 26 worker, consumer and provider organizations as well as interested individuals. The DCWC mission is to promote policy and practices that respect and value direct care workers in order to sustain quality direct care in Maine. The DCWC is currently working with the Maine Departments of Health and Human Services and Labor on a legislatively mandated study that includes determining the cost to the Medicaid program of a $10 wage floor for all direct care workers in state funded programs; health coverage options, and new objectives for an expanded direct care worker registry. DHHS will report the findings to the legislature in January 2007.

Through private foundation awards, Maine is participating in the Northern New England LEADS Institute (Leadership, Education and Advocacy for Directcare Staff) with New Hampshire and Vermont in a three-year project offering training and support to long-term care organizations and their frontline staff to improve workplace culture and worker retention. Staff partners for the Maine sites include Coastal Enterprises, Inc. and the University of Southern Maine Muskie School of Public Service.

Through a four-year grant to the state from the federal Centers for Medicare and Medicaid Services, Maine has been doing outreach to home care providers to demonstrate and evaluate ways to improve recruitment and retention of direct service workers. While a primary question being tested is the value of affordable health insurance most providers have indicated that, although they want to offer health insurance to their frontline staff, they cannot under the current Medicaid reimbursement rates. Evaluation of this effort is underway.

The Maine Association for Community Service Providers is participating in a partnership with ANCOR (American Network of Community Options and Resources), the U.S and Maine Departments of Labor to improve recruitment and training of direct support professionals that work with people with mental retardation and developmental disabilities.

Maine PASA and the Maine Center for Economic Policy have both been working with the Paraprofessional Healthcare Institute on a "Health Care for Health Care Workers" campaign in 2006. This has involved research and information dissemination on the health coverage status of direct care workers and potential options for expanding coverage. (see attached fact sheet)

The Kennebec Valley Organization, a broad-based regional organization of religious congregations, labor union locals, community and small business groups has taken on a direct care workforce issue campaign this fall. The organization is holding listening sessions in their local communities on the connection between improving direct care job quality and improving the quality and availability of long-term care in Central Maine.

A Direct Care Workforce Policy Agenda

The following policy agenda comes from the findings of the aforementioned initiatives and best practices in other states:[xvii]

Coordinate State Level Planning Efforts to Meet this Workforce Demand

1. Create a state-level Direct Care Workforce Committee with representatives from all relevant state departments; all types of provider agencies; workers; and consumers to help establish the worker shortage as a priority policy issue and monitor the care gap and contributing factors. The Committee will work to ensure a comprehensive examination of the direct care, direct support, and consumer directed personal assistance workforce:

    - Estimate current and projected long-term care consumption and workforce needs.
    - Collect data on the wage, benefit, and reimbursement structures in each sector of the industry: nursing facilities, residential care, home care.
    - Conduct regular surveys of this workforce to determine its status and needs.
    - Establish benchmarks for evaluating employer performance in the areas of turnover; absenteeism; injury rates; wages and benefits; health insurance provided; on-site education and opportunities for wage progression; workloads; current and projected direct care vacancies; and the percentage of overall expenditures on staffing.
    - Coordinate state health, labor, welfare, education and economic development policies as they relate to this workforce:

- Assess total current public funding flowing to this workforce – including from public assistance programs – in order to rationalize the use of public funds for best effects.
- Coordinate labor market data collection and analysis across state departments.
- Coordinate training resources.
- Coordinate programs to match, train and support transitional and displaced workers for direct care jobs.
- Implement policies that support employers' efforts to recruit, train and retain workers.

- Implement policies to reduce injury rates to protect worker health and stability on the job and to lower providers' workers compensation costs.

Provide Livable Wages and Benefits to Frontline Direct Care Workers

2. Establish a livable wage scale for this workforce, with a floor of at least $10 per hour in 2007. Increase public funding to allow employers to raise wages on this scale in a stepped up fashion over a ten-year period, adjusting annually for inflation.
3. Create wage and benefit parity across the various direct care occupations and settings in order to equitably reward workers with similar skills and responsibilities and to encourage job mobility within the field.
4. Extend Medicaid or other health insurance coverage to all uninsured direct care workers and their families.
5. Support the development of provider consortia to create full employment positions across participating employers in regional areas.
6. Provide workers with child care assistance and adequate transportation reimbursements.
7. Establish employer work support programs to offer employees revolving loan funds, tuition assistance, individual development accounts, and earned time for continuing education.

Invest in Training, Career Pathway Development and Workplace Culture Changes

8. Develop and support management training that includes communication, coaching, conflict management, team building, and reward and recognition strategies.
9. Design a coordinated system of learner-centered training based on researched training standards. Develop a cross training system between direct care occupations and a credentialing system that can be applied to advanced education. Training should include hands-on practice as well as problem solving and communication skills.
10. Implement peer mentoring as part of ongoing orientation and training and financially reward peer mentors.
11. Provide funding for demonstration grants for employers and consortia to establish good management practices and workplace culture changes.
12. Promote quality improvement management structures that promote teamwork, coaching, recognition, evaluation, and respect.
13. Implement career steps for workers with a reimbursement restructure that rewards longevity and increased skill development.

Market the Direct Care Profession

14. Designate a Maine Personal Assistance Day to give recognition to exemplary workers across the state.
15. Publicize the existence of career pathways to improve the reputation of direct care jobs.
16. Fund public relations campaigns and other initiatives to market direct care career opportunities to students, displaced workers and other individuals seeking career changes.

Barriers to Policy Agenda Implementation

This ambitious policy agenda faces two key barriers for implementation. The first is inertia on the part of policymakers. There is a continuing lack of recognition and attention to the fact that Maine is already failing to meet the needs of seniors and adults with disabilities because of the workforce shortage. The edge of the cliff is not before us – we have already fallen over. The cleft into which we are falling just gets deeper and deeper in the years ahead. Providers have cut every fiscal corner there is to cut and are absorbing losses in order to continue to offer these services. Workers are heading for other jobs. The state response so far has been too slow and laissez faire.

The second barrier is one of attitude and growing tension about state spending in general and Medicaid spending in particular. Maine's population is older and has lower incomes than other states. We have committed to providing health coverage for hard working low-wage families that have no other access. As such, one out of five Mainers currently relies on Medicaid for health coverage and long-term care, with the latter accounting for the largest portion of spending. Such health care spending has been growing at about 8% per year, a much lower rate of increase than in the private health insurance market. However, state revenues have been growing at around 2% per year. This fact, coupled with the growing demand for tax relief puts state policymakers in a difficult and often untenable position.

Balancing the state budget is always an exercise of balancing the demand for many vital services with limited resources. But we have not done a good job of explaining to the public the connection between the services they want and value and the inevitable associated costs. Calls for arbitrary tax and spending limits remind us that many citizens do not understand that their tax dollars are being used to support critical public structures – like the long-term care system. We do not want to be in a position of pitting quality education for our children against quality long-term care for our elders, for example. In fact, more resources are needed for both if we want to grow Maine's economy, attract new businesses, and ensure a healthy population.

We must all work to help the public recognize the importance of investing our state resources wisely and of adequately funding the services we have collectively decided we need for a reasonable quality of life in Maine. This barrier of attitude can be overcome, but not without conscious effort.

Implications for Individuals and Communities

Maine loses valuable worker productivity due to the workforce shortage. More and more working families are interacting with the long-term care system as their parents age and need services. Working adults are often stressed on the job because they fear from experience that their elderly mother or father will not actually have the direct care visit in their home that they are supposed to have on a particular day. They witness the revolving door of frontline workers when they visit the nursing home. Most families cannot afford to pay the going rate of $15-20/hour for private home care arrangements and few are in the position of paying privately for long-term care facilities.

Vulnerable elders and adults with disabilities are going without the care they need. Consumer satisfaction surveys indicate that most cherish the direct care worker that helps them and that the quality of their care is greatly diminished by constant turnover. They need us to help advocate on their behalf.

Dedicated direct care workers are not earning enough to support themselves and their families. They are discouraged by the lack of respect they and the people they care for are afforded by the current system of compensation and support. It is no wonder that they leave the field for jobs that pay better.

We can do better than this. It is time for Maine to come to grips with the direct care worker shortage and its implications for all of our communities and the state's future. We must change our assumptions and strategies and create jobs that will attract workers before the crisis grows even more severe. Maine's vulnerable citizens, and Maine's current and potential direct care workers, deserve our full commitment.

Appendix 1
Resources

Better Jobs Better Care
Robert Wood Johnson Foundation
http://www.rwjf.org/applications/solicited/npo.jsp?FUND_ID=55082

Direct Care Alliance
http://www.directcarealliance.org/

Maine Center for Economic Policy
http://www.mecep.org

Maine Personal Assistance Services Association (Maine PASA)
http://www.mainepasa.org

National Clearinghouse on the Direct Care Workforce
http://www.directcareclearinghouse.org/index.jsp

Paraprofessional Healthcare Institute
http://www.paraprofessional.org/

U.S. Department of Health and Human Services
May 2004 Symposium on Recruitment and Retention of Direct Care Workers
http://aspe.hhs.gov/daltcp/reports/04cfpack.htm

Endnotes

[i] Paraprofessional Healthcare Institute. 2000. Direct-Care Health Workers: The Unnecessary Crisis in Long-Term Care.

[ii] Maine Occupational Wage Data. May 2005. www.bls.gov

[iii] The Massachusetts Health Policy Forum. 2000. Health Care Workforce Issues in Massachusetts. Issue Brief No. 9.

[iv] U.S. Bureau of the Census. Population Projections for States. http://www.census.gov/population/projections/state/9525rank/meprsrel.txt

[v] Maine Hospital Association. Maine's Long Term Care Workforce: A Special Report Examining the Implications of a Growing Labor Shortage on Access to Long Term Care. October 2001.

[vi] Paraprofessional Healthcare Institute. 2000. Direct-Care Health Workers: The Unnecessary Crisis in Long-Term Care. p. 3.

[vii] Maine Department of Education. Decline from 1,996 in 2002 to 1,377 in 2004.

[viii] Maine Center for Economic Policy. Getting By: Livable Wages in 2004. 2005.

[ix] GAO Testimony by William Scanlon, Director, Health Care Issues. Long Term Care-Baby Boom Generation Increases Challenge of Financing Needed Services. 3/27/01, p. 23.

[x] Paraprofessional Healthcare Institute.

[xi] Seavey, Doris, The Cost of Frontline Turnover in Long-term Care, IFAS/AAHSA, October 2004.

[xii] Assisted Home Care II in Lewiston as of November 2002 charged the following hourly rates: CNAs $22 and weekend/holiday $25; PCAs: $20 and weekend/holiday $23.00.

[xiii] U.S. Department of Health and Human Services. Office of the Inspector General. Nurse Aide Training. November 2002. OEI-05-01-00030.

[xiv] Four focus groups totaling 38 current and former paraprofessional health care workers across New Hampshire, conducted by the New Hampshire Community Loan Fund. Concord. MNE. January and February 2000, as cited in Paraprofessional Healthcare Institute. 2000. Direct-Care Health Workers: The Unnecessary Crisis in Long-Term Care. p. 6; Dresser, Laura, Dori Lange, and Alison Sirkus. Improving Retention of Frontline Caregivers in Dane County. Madison: Center on Wisconsin Strategy. March 1999. p. 23; In Their Own Words: Pennsylvania's Frontline Workers in Long Term Care. A Report to the Pennsylvania Intra-Governmental Council on Long Term Care. February 2001.

Endnotes (Continued)

[xv] Maine Department of Labor. Bureau of Labor Standards. Occupational Injuries and Illnesses in Maine, 2000. Calculated as 1,197 injuries per 17,280 direct care workers = 6.9 incidences per 100 workers, and 17,283 Workers' Compensation injuries and illnesses in 2000 and an estimated 582,870 state, local and private workers in Maine for 3.0 incidences per hundred workers.

[xvi] As an example of the impact of training, the logging industry had a Lost Workday case rate of 13.0 in the early 1990s so the Certified Logging Professional (CLP) training program was introduced and was so successful that insurers began providing premium incentives to employers who hired workers that went through that training. John Rioux, Maine Bureau of Labor Standards.

[xvii] This policy agenda was first formulated by the Direct Care Worker Coalition and published in Pohlmann, Lisa. 2003. Without Care: Maine's Direct Care Worker Shortage. Augusta: Maine Center for Economic Policy.